UAI / PLAN OF CARE

Customer Name: _____ Social Security #: _____ Medicaid #: _____

Provider Name: _____ Provider ID #: _____

Case Management Initiated: _____ Medicaid Eligibility Approved: _____
(Date) (Date - if after date initiated)

MEDICAID CLIENTS ONLY:

Initial Authorization: _____ Reauthorization: _____
(Must submit to DMAS prior to billing) (Must request 2 weeks prior to end date)

GOALS: *(Circle one or more)*

1. To assist client to remain in his/her own home with supports, as necessary.
2. To assist client in attaining and maintaining appropriate independent functioning based on his/her capabilities.
3. To assist in arranging out-of-home placements as appropriate with either client/guardian consent or court orders.
4. Short-term assistance to access services.

Other Goals: _____

Unmet Need from UAI Summary	Measurable Objective to meet Identified Need	Task(s) to be done to meet Objective	Expected Time Frame	Date Resolved

Client Name:_____ Social Security # _____ Medicaid # _____

Unmet Need from UAI Summary	Measurable Objective to meet Identified Need	Task(s) to be done to meet Objective	Expected Time Frame	Date Resolved

SIGNATURES _____ _____ _____ _____

(Recipient of Services) (Date) (Case Worker) (Date)

CASE MANAGER COMMENTS:

Enrolled by DMAS: Service Effective _____ Thru End Date _____ DMAS Analyst _____ Date Entered _____